LETTERS TO THE EDITOR

Lymphatic filariasis—lest we forget

EDITOR,—Lymphatic filariasis is characterised by a wide range of clinical manifestations. In a non-endemic area the diagnosis may be missed unless the index of suspicion is high.

An 18 year old sexually active male presented with a progressively increasing painless nodular swelling in the right inguinal region of 4 months' duration. The patient had an unprotected vaginal contact with a commercial sex worker 6 months earlier. There was no history of genital ulcer or urethral discharge. The general health of the patient was preserved. Examination revealed enlarged right inguinal and external iliac lymph nodes, 1–3 cm in size, firm, mobile, non-tender, and matted with normal overlying skin. Examination of genital, anal, and buccal mucosae was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum (LGV) and tubercular lymphadenitis was considered. Complete blood count revealed mild leucocytosis and eosinophilia. Renal and hepatic functions, urinalysis, and chest *x* ray were normal. Mantoux test and VDRL were negative. A complement fixation test for chlamydia group specific antibody was negative. Fine needle aspiration cytology from the nodes revealed reactive hyperplasia with occasional giant cells and microfilariae of *Wuchereria bancrofti*. Nocturnal blood samples for microfilariae were negative.

The patient was given diethylcarbamazine 100 mg thrice daily for 2 weeks. The lymph nodes regressed and no relapse was observed in 6 months of follow up.

The differential diagnosis of inguinal lymphadenopathy in a sexually active male includes syphilis, genital herpes, chancroid, LGV, pyogenic adenitis, tuberculosis, and lymphoma.[1] In the present case a diagnosis of LGV was considered in view of a history of sexual contact, painless and non-suppurative lymphadenopathy not apparently preceded by a genital ulcer.

Demonstration of microfilariae was decisive in clinching the diagnosis of filariasis which was not considered in the differential diagnosis. Presentation with inguinal lymphadenopathy is a feature common to both LGV and filariasis. The most frequent manifestation of secondary stage of LGV in men is unilateral inguinal lymphadenopathy which does not suppurate in two thirds of cases.[1] Iliac lymphadenopathy often develops in LGV as was observed in our patient.[2] Painful enlargement of inguinal lymph nodes with fever is the usual presentation in lymphatic filariasis. Lymphangitis can accompany recurrent attacks. Other complications include orchitis, funiculitis, and epididymitis.[3 4] These were, however, absent in our patient. It is suggested that lymphatic filariasis should be considered in differential diagnosis of inguinal lymphadenopathy even in areas which are not known to be endemic for it. It is otherwise likely to be missed.

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Canary to sparrow; what is in a name?

EDITOR,—The Contagious Diseases Act of 1864 allowed for the compulsory arrest, examination, and treatment of women considered (by an all male board) to be of loose morals. Women were detained in the so called "Canary wards" and their identity made clear by the bright yellow garments they were made to wear.

In the year 2000, there is still perceived stigma and blame associated with the diagnosis of sexually transmitted infections (STIs) and this must be minimised if a screening programme for chlamydia is to be successful. It will help reduce stigma if people know and accept that it is not a disease of a few readily identifiable people but that it is common and easy to acquire. It has been estimated that one in 14 young people will acquire it at some time.

In the NHS chlamydia pilot screening programme in Wirral and Portsmouth we are confirming that this infection is indeed endemic. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included testing of men in some settings and have introduced instead of sexually transmitted, the term "sexually shared infection."

We hope that by measures such as these, young people will avoid stigmatisation as "canaries."

We do not, however, suggest that you change the name of your journal again!

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Acceptability of home screening for chlamydial infection: some remaining issues

EDITOR,—In the recent article by Stephenson *et al*[1] the authors describe participation rates of 39% for women and 46% for men for home screening and comment "that this might form a useful component of a community based chlamydial screening programme in which non-responders could be offered opportunistic screening at the general practice." However, certain crucial issues remain unanswered. This acceptability survey was done among women aged 18–25 years and men 18–30 years. What happens with people below the age of 18? We know that *Chlamydia trachomatis* prevalence is associated with young age, but can we also send home screening kits to 15 year olds? What about the parental opinions and legal implications—for example, for the partner of a *C trachomatis* positive youngster?

In two surveys performed in general practice in Amsterdam, Netherlands, using systematic and opportunistic screening, prevalence was strongly associated with young age but also with ethnicity. Among young Surinam-Antillian women aged <25 years, prevalences ranged from 5.4% in the systematic survey up to 22.4% in the opportunistic survey.[2 3] In the systematic survey an unexpectedly high *C trachomatis* prevalence of 10% was found among young Surinam-Antillian men. Among the 15–19 year olds visiting our health centre in Amsterdam which is located in a multiethnic neighbourhood, half of the population having a Surinam-Antillian background, *C trachomatis* prevalence was 25%.[4]

Thus, the question is not only how acceptable home screening is for the youngest age group, who might be most at risk, but also how acceptable home testing is for people with different ethnic backgrounds and people living in low socioeconomic status and high risk environments.

We piloted a pharmacy assisted approach offering urine home testing to all sexually active women age 15–30 years who come to our pharmacy to collect their contraceptives. Since the start 4 months ago 189 people received an information leaflet and home test package together with their contraceptives. Fifty nine participated and sent their urine; four were positive (6.7%).[5] The participation rate was 31%, lower than the reported rate for women in the article of Stephenson *et al*.

The assumption by the authors that people who do not participate for home screening will turn up for opportunistic screening at the general practice is, however, merely a hypothesis, and not a strong one, especially not for boys and men.

Tackling issues like risk perception and risk environment and changing healthcare seeking behaviours is not an easy task. Moreover, a community based *C trachomatis* prevention programme will require not only secondary prevention by active case finding but also primary prevention. What is needed is an integrated set of strategies, which are mutually reinforcing and that are age, sex, culture, and context specific. Quite a challenge!

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Nurse counselling for women with abnormal cervical cytology improves colposcopy and cytology follow up attendance rates

EDITOR,—A well organised cervical screening programme has considerable benefits; however, one negative aspect is anxiety associated with abnormal results. The NHSCSP guidelines state that an explanatory leaflet should be given to women with abnormal cytology and those being referred for colposcopy, with a verbal explanation wherever possible.[1] We assessed if there is any additional benefit from a verbal explanation, following written information, when an abnormal smear result is given, in understanding and future attendance for colposcopy and cytology follow up.

Between April and December 1998 we recruited 89 women with abnormal cytology. All women attending for results are given the NHSCSP leaflet "What your abnormal result means" if their smear shows borderline changes, mild, moderate, or severe dyskaryosis. The study women completed a questionnaire after reading the leaflet. A nurse (BH) then gave a verbal explanation about the smear result. They then completed the questionnaire again. Attendance for colposcopy and cytology follow up was recorded, default being defined as non-attendance without cancellation. Default rates were compared with other women with abnormal cytology during the same period. They were not included in the study as they attended when the specified nurse was not available. They had all received the leaflet but not a structured explanation.

The explanation for each woman took approximately 15 minutes. The results of the questionnaire before and after explanation are shown in table 1. There was a significant improvement in understanding and reduction in anxiety. The control group comprised 104 women. In the study group 65 required colposcopy; three (4.6%) defaulted, compared with seven of 38 (18.4%) women not receiving a verbal explanation; p= 0.03 Fisher's exact test; OR 0.21 (95% CI 0.03–1.03). Of the study group, 81 should have attended for follow up cytology 6 months after colposcopy or smear showing borderline changes; 12 (15%) defaulted compared with 37 of 95 (38.9%) women not receiving a verbal explanation; p= <0.001 χ^2 test; OR 0.18 (95% CI 0.08–0.41). Eventually only one (1.5%) in the study group and two (5.3%) of the controls did not attend for colposcopy, and 11 (13.8%) and 24 (25.3%) for follow up cytology.

Despite the leaflet the women in our study still had misunderstandings and anxieties. The verbal explanation helped clarify these. Verbal information can be tailored to the individual, some requested detailed descriptions, others preferred a simpler explanation (as reported previously[2]). This is not possible with written information. Marteau *et al* found that a brief, simple booklet increased knowledge and reduced anxiety whereas a more complex booklet increased knowledge but did not reduce anxiety.[3]

The default rates were lower in those receiving the verbal explanation. Lerman *et al* found that women with abnormal cytology who defaulted colposcopy appointments were more worried about cancer with impairment of mood and sleep.[4] Following the explanation our default rate for colposcopy was within the 15% recommended target,[5] and follow up cytology was similar to the rates reported in primary care.[6]

There are deficits in this study. The lack of randomisation means the improvement in default rates could be the result of baseline differences rather than the verbal explanation. However, it has shown benefit to the women by improving understanding. The department has also benefited; although extra nursing time has been required, the lower default rates for colposcopy and cytology has reduced the clerical, medical, and secretarial time normally required recalling non-attendees.

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Table 1 The questionnaire results before and after the verbal explanation

Question	*Response (n=89)*	*Before*	*After*	*χ^2 test p value*
How well do you understand the result you have been given?	Not at all	26	1	
	A little	36	13	<0.0001
	A lot	27	75	
Are you worried about the result of your smear test?	Yes	45	13	
	A little	42	60	<0.0001
	No	2	16	
Will it worry you if we need to do further investigations?	Yes	36	11	
	A little	40	46	<0.0001
	No	13	32	
Are you worried that further investigations will be painful?	Yes	55	28	
	Don't know	11	14	0.0002
	No	23	47	
Do you think that any abnormality found can be treated?	Yes	61	85	
	Don't know	25	4	<0.0001
	No	3	0	
Do you think you have cancer?	Yes	5	1	
	Don't know	34	9	<0.0001
	No	50	79	
Do you think this smear result will affect your ability to have children?	Yes	15	2	
	Don't know	34	10	<0.0001
	No	40	77	
Do you think this result will change your attitude to sex with your partner?	Yes	18	13	
	Don't know	30	14	0.004
	No	41	62	
Do you think this result will affect the way your partner thinks of you?	Yes	8	4	
	Don't know	13	10	0.36
	No	68	75	

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Phone sex: information technology (IT) and sexually transmitted infection in young people

EDITOR,—The recent article on the acceptability of home testing for chlamydia was noted.[1] We would like to extrapolate this concept. Young people could be accessed via an internet clinic. Our experience during the chlamydia pilot study is that this population makes extensive use of technology, in particular mobile phones. The presence of sex on the internet has been widely publicised. We propose that testing for sexually transmitted infection (STI) via the internet is the next logical step.

The chlamydia pilot study was funded by the Department of Health, to investigate the feasibility of screening 16–25 year old women (and some men), for chlamydia, using a urine specimen. Antibiotics for chlamydia are cheap and effective. The cost of complications to the individual is enormous, as is the cost to the NHS—£200 million per year.[2] Screening reduced the prevalence of infection in Sweden and the United States.[3] Computer modelling suggests that screening in this country would be cost effective.[4]

After screening for chlamydia, a means of contacting clients to give results was arranged—for example, letter or phone call. On the Wirral, 2651 patients were screened in the first 4 months—2332 women and 285 men (34, sex not recorded). Sixty eight (2.6%) gave a mobile phone number, half (35) using this as their *only* means of contact. Sixty five were female and two male (one patient not recorded). Thus, women (2.8%) were more likely to use mobile phones than men (0.7%) (p = 0.03). The genitourinary medicine (GUM) clinic screened 358 patients. Only 68 (19%) gave an address. The results of a further 469 (17.7%) of the screened population went back to the screening site. These clients could be interested in contact via mobile phone if it was openly offered (data collected from the Public Health Laboratory Service (PHLS) database and analysed on EPI-INFO 6).

According to a survey by NOP Social and Political, confidentiality is important to people in the target age group (unpublished data). Patients consider their mobile phones to be a secure method of communication between themselves and us. The advent of DNA amplification in the detection of STIs has opened up new possibilities.[5 6] There are 30 000 websites pertaining to chlamydia. An internet clinic would be aimed at mildly symptomatic or asymptomatic patients. The client would access the website and request swabs or urine pots through the post then return them the same way.

If the patients were positive, they would need to attend a GUM clinic or equivalent.